



**NASH HEALTH CARE**  
*It's all about how we treat you*

DATE: \_\_\_\_\_

PATIENT QUESTIONNAIRE

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SEX: \_\_\_\_ MARITAL STATUS: (CIRCLE ONE) S M W D

CURRENT OCCUPATION OR OCCUPATION BEFORE RETIRING: \_\_\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_ PRIMARY CARE PHYSICIAN: \_\_\_\_\_

MEDICATION ALLERGIES:

\_\_\_\_\_

DO YOU SMOKE?: \_\_\_\_\_ IF YES, HOW MUCH?: \_\_\_\_\_ PER DAY IF STOPPED, WHEN: \_\_\_\_\_

DRINK ALCOHOL? \_\_\_\_\_ IF YES, HOW MUCH?: \_\_\_\_\_ PER DAY RIGHT HANDED/ LEFT HANDED

REASON FOR VISIT: \_\_\_\_\_

LIST ALL SURGERIES INCLUDING DATES:

\_\_\_\_\_  
\_\_\_\_\_

IF SURGERY IS REQUIRED, DO YOU ACCEPT BLOOD PRODUCTS?: \_\_\_\_\_

CURRENT MEDICATIONS: (INCLUDE DOSE AND HOW TAKEN):

\_\_\_\_\_  
\_\_\_\_\_

WHAT PHARMACY DO YOU USE?: \_\_\_\_\_

HAVE YOUR PHARMACY FAX ALL REFILL REQUESTS. NO REFILLS ON FRIDAY'S. ALLOW 2-5 DAYS FOR REQUESTS TO BE COMPLETED. \_\_\_\_\_ (INITIAL THAT YOU HAVE READ THIS REFILL POLICY)

MOTHER LIVING Y N IF NO WHAT WAS CAUSE OF DEATH: \_\_\_\_\_ AGE AT DEATH: \_\_\_\_\_

FATHER LIVING Y N IF NO WHAT WAS CAUSE OF DEATH: \_\_\_\_\_ AGE AT DEATH: \_\_\_\_\_

REVIEW OF SYSTEMS: PLEASE CHECK ANY THAT APPLY TO YOU:

<input type="checkbox"/> ASTHMA <input type="checkbox"/> TUBERCULOSIS <input type="checkbox"/> SHORTNESS OF BREATH <input type="checkbox"/> CHRONIC COUGH <input type="checkbox"/> HEART TROUBLE <input type="checkbox"/> PALPITATION OF POUNDING HEART <input type="checkbox"/> HIGH OR LOW BLOOD PRESSURE <input type="checkbox"/> CRAMPS IN YOUR LEGS <input type="checkbox"/> BROKEN BONES <input type="checkbox"/> ARTHRITIS <input type="checkbox"/> BACK PAIN <input type="checkbox"/> FREQUENT OR SEVERE HEADACHES <input type="checkbox"/> DIZZINESS OR FAINTING SPELLS <input type="checkbox"/> EYE TROUBLE <input type="checkbox"/> EAR, NOSE, OR THROAT TROUBLE	<input type="checkbox"/> HEARING LOSS <input type="checkbox"/> SINUSITIS <input type="checkbox"/> HEAD INJURY <input type="checkbox"/> SEIZURES <input type="checkbox"/> PARALYSIS <input type="checkbox"/> THYROID TROUBLE <input type="checkbox"/> SKIN DISEASE <input type="checkbox"/> FREQUENT INDIGESTION <input type="checkbox"/> STOMACH ULCERS <input type="checkbox"/> HEPATITIS <input type="checkbox"/> YELLOW JAUNDICE <input type="checkbox"/> GALLBLADDER TROUBLE <input type="checkbox"/> CONSTIPATION <input type="checkbox"/> DIARRHEA <input type="checkbox"/> DIVERTICULOSIS <input type="checkbox"/> CANCER	<input type="checkbox"/> FREQUENT OR PAINFUL URINATION <input type="checkbox"/> INABILITY TO CONTROL URINE <input type="checkbox"/> BLOOD IN URINE <input type="checkbox"/> SUGAR IN URINE <input type="checkbox"/> DAIBETES <input type="checkbox"/> KIDNEY STONES <input type="checkbox"/> RUPTURE/ HERNIA <input type="checkbox"/> RECENT LOSS OR GAIN OF WEIGHT <input type="checkbox"/> BLEEDING DISORDERS <input type="checkbox"/> LOSS OF MEMORY OR AMNESIA <input type="checkbox"/> PERIODS OF UNCONSCIOUSNESS <input type="checkbox"/> NUMBNESS OF BODY PART <input type="checkbox"/> SEXUALLY TRANSMITTED DISEASE <input type="checkbox"/> ADVERSE REACTION OF MEDICINE <input type="checkbox"/> OTHER (PLEASE EXPLAIN): _____
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